Commentary on the Keynote Address

BARBARA A. DEBUONO, MD*

In his presentation Dr. Stocker offered a litany of predictions. I don't think that I have been around long enough to make all those predictions, but suffice it to say that, in answer to Dr Johnson's question, I am not pessimistic for New York State. I do believe, however, that it is to our great shame, as a nation, that we do not have universal access to coverage and care. In New York State we will adopt, for the next several years, an incremental approach to universal care and coverage.

I was intrigued by Professor Reinhardt's observation about Republican administrations. I am in one now; we are seeking increasingly to create an environment where managed-care organizations are more accountable to the public, the government, and certainly to businesses. New York, like New Jersey, has passed a 48-hour maternity bill, although ours is different in the way in which we involved hospitals in assuring that women have access to at least 48 hours if they so choose.

Dr. Stocker alluded to a bill introduced by Governor Pataki shortly before the Margaret E. Mahoney Symposium convened. The omnibus managed-care bill has some interesting features that address the issue of increasing demand that state governments will be placing on the health-insurance industry, to both raise the bar and the level of standards around quality, accountability, and access to information for plan enrollees, government, and the public.

In the New York State we are expanding our presence with

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* Dr. DeBuono is Commissioner, New York State Department of Health.

regard to managed-care oversight. We have created within the Department of Health an Office of Managed Care that coordinates this oversight and manages the state's Medicaid managed-care program. We have moved approximately 40 employees from the Department of Social Services and about 80 employees from other agencies, to create an Office of Managed Care that reports directly to me. This has been a very important administrative step; it enables the state to coordinate its response to this burgeoning insurance product.

The Governor is interested in levelling the playing field among insurers that participate in managed care, not just traditional HMOs, but other plans that are combinations of PPOs, where risk is being passed on even partially. Our view is that all managed-care products should fall under some sort of scrutiny, from government and from the private and public sectors.

What has happened with managed care in New York State? Growth has been tremendous in the last 5 years: about 40% of insured New Yorkers are in managed care, about six million people. This growth is reflected in different ways and different places across the state.

Some of the largest markets for managed care in New York State are Erie County, where the penetration is about 60%, and Monroe County, where managed care enrolls about 70% of the population. Managed care is not common elsewhere, such as in Allegheny, Steuben, and Chemung Counties—all the southern tier—where we see approximately 5% penetration. The area around the Capital District—Saratoga, Schenectady, and Albany Counties—all have 40% to 50% penetration, whereas penetration hovers at around 30% in the New York City area and Westchester County. The dominant markets for managed care in New York State, therefore, are found at present in the areas of Rochester, Buffalo, and Albany.

This tremendous growth of managed care is an option that many New Yorkers are not part of, either by choice or by necessity. In concert with the public, consumer groups, advocates, the media, and providers, the state has resolved to put some discipline in the

oversight of this system. It is with that in mind that the Governor commissioned a group to develop a comprehensive managed-care bill.

The legislation is unique for several reasons. It is extraordinarily comprehensive in addressing a large array of issues that concern providers, consumers, and government. It applies to a broad range of insurance products currently offered in New York State; it is not only traditional HMO regulation, but regulates a variety of different types of products where both risk and partial capitation begin to occur.

The legislation was collectively and collaboratively developed in a unique public/private partnership, wherein advocacy groups, consumer groups, the Medical Society of New York, many legislators, managed-care plans, and employers all came together. As a result, when the bill was announced, the Governor of the State of New York and the head of the New York Public Interest Research Group (NYPIRG), Blair Horner, shared a podium, shook hands, and stood for a picture, probably for the first time. That was quite unique.

Some components of the bill are of great concern to individuals in New York State and in this country. The bill includes provisions for disclosure of information to consumers, creating uniform standards for grievance and appeals, and ensuring access to emergency care. It also addresses the issue of access to specialty care for the chronically ill: individuals who suffer from chronic or life-threatening conditions, for whom access to specialists is becoming increasingly difficult, especially without prior approval of a primary-care physician.

In addition, the bill addresses the issue of decision-making criteria and the degree to which HMOs actually use clinical guidelines and standards created by national bodies in the decisions they make. Utilization review needs to be comprehensively addressed; the bill does so.

Providers have very serious concerns about their ability to practice in an environment where, increasingly, they feel that restrictions are placed on the decisions they make and the things that

they can say to patients. Professor Reinhardt closed his talk with a picture of a doctor with a rag in his mouth; this bill prohibits plans from restricting a provider's ability to discuss treatment options with patients, including those that may be costly, or not covered by a plan.

The bill requires HMOs to provide prospective providers with a list of the minimum qualifications for them to join a managed-care network. Plans will not be allowed to terminate providers without giving reasons for termination and offering the provider an opportunity to challenge the HMO's decision through a hearing that will be conducted by a three-member panel, one member being a clinical peer of the terminated physician.

Transfer of liability is another issue of great concern to providers. HMOs will be prohibited from transferring legal liability to a health-care provider for any of the organization's activities, actions or omissions. In addition, there will be no penalties that HMOs can levy on providers for filing complaints with bodies such as the New York State Health Department or Insurance Department.

I have been concerned about the state's role in overseeing managed care. Historically, my department has focused most of its health-care monitoring on hospitals, nursing homes, facilities, and institutions, because those were the places where most of the decisions about health care and activities involving health care were taking place. The growth of managed care, in my opinion, requires that we greatly strengthen our oversight role and that we turn our attention toward compliance with a plan, with an entity, in its role and responsibility to be accountable to the public and to government in the care that it delivers.

The bill contains specifications that ensure our department's authority to determine the adequacy of plan networks in terms of access to primary-care providers and specialists. In addition, it clarifies our ability to obtain patient-specific data from managed-care plans, to fulfill our responsibility for quality-of-care oversight and to for investigations of complaints. This has been an area of great debate between managed-care organizations and the Health Department. Our view is that the amount of information that will

be demanded of government and the health-insurance industry—by consumers, providers, and others, including businesses—is just beginning to explode and will continue to burgeon over the coming years. We think it important, therefore, that there be some objective arbiter for these data, ensuring both the completeness and the accuracy of the data and their interpretation.

Registration for utilization review and oversight of point-of-service plans and other insurance is also included in the bill. The information that consumers will be able to get about their plans includes a great degree of detail. I do not think that we will find people really taking advantage of this amount of detail, but we do think that people who request information ought to be able to get it, particularly when it comes to understanding the benefit package. In the same vein, clinical guidelines and the criteria that are used to make treatment decisions also need to be shared with consumers. Careful and accurate packaging of such information is essential, however, if consumers and enrollees are not to suffer from information overload.

Issues about drugs and formularies are controversial. Should drug benefits be in or be out of managed care? That issue is being addressed legislatively now. We believe, however, that formularies and the kinds of drugs covered by plans are important information and need to reach consumers and enrollees.

Grievances constitute another area where we have attempted to level the playing field by establishing standardized processes. There is great variability in New York: some plans have very strenuous appeals processes and execute them well; others have poor programs and do not exercise them as well. We have sought to create a uniform standard across all plans for grievance and appeals.

Similarly, plans should have strong utilization review processes; in fact, they should be exercised and strengthened. We do not want to create a government bureaucracy around grievances, appeals and utilization review; the bill, therefore, keeps both utilization review and grievance appeals within plans and seeks to strengthen those procedures and ensure that the plans are follow-

ing, monitoring, and implementing those procedures that they have in place.

I believe then, as does our Governor, that managed care is a permanent and important part of our health-care landscape in New York. I agree that we will continue to find the need, desire, and political will from the public to have fee-for-service and indemnity insurance, but I also see, increasingly in New York, a larger segment of the market moving into managed care. I think that employers as well as employees will be making those decisions on a voluntary basis. However, the time has come to establish the rules of the game; government, in its role as overseer, can make sure that those rules are followed. That is what we are doing in New York State.